RFP# 305PUR-DHHRFP-DBP-MVA
QUESTIONS AND ANSWERS (1-3-2012)

Question #	Submitter Name	Document Reference	Section Number	Section Heading	Page Number in Referenced Document	Question	DHH Response
1	Ward Blackwell, LDA	RFP		Letter of Intent		What is the correct interpretation of the instructions for the DHH provider letter of intent?	Per Section 21.10.3.1 of the RFP, proposers are requested to submit a letter of intent to the RFP coordinator.
2	Delta Dental	RFP	1.9	Schedule of Events	4	Due to the holidays, would DHH consider extending the deadline for receipt of written proposal by 30 days?	No.
3	Coventry Health Care LA					1. Will claims data be provided? If so, we would like to request 24 months of claims versus membership counts broken out month by month. Current member census in excel with zip codes OR breakdown of membership by zip code.	1. Yes. 2. Format of data is specified in Appendix H - Health Plan Data Use Agreement for more details.
4	Coventry Health Care LA	RFP	26	Dental Services Manual		Please provide the Medicaid dental fee schedule for services.	The most current fees are posted on the www.lamedicaid.com website. The current Early Periodic Screening Diagnostic and Treatment (EPSDT) fee schedule is also located in Appendix A of the Dental Services Manual.
5	DentaQuest	Dental Services Manual		Dental Services Manual	13	This statement contradicts with Appendix O, Section 16.5, page 14 which states: "Please not e that restorations are only reimbursable for Tooth Number D, E, F, G, N, O, P and Q for recipients who have reached their fifth birthday." Please provide clarification on if the services are covered for childeren who have reached their fifth Birthday	A correction will be made to the Dental Policy manual to read "Please note that restorations are only reimbursable for Tooth Number D, E, F, G, N, O, P and Q **if the recipient is under 5 years of age.**"
6	DentaQuest	RFP	2.3.5	General DBPM Requirements	7	Are Adults covered under the program? Can DHH please clarify what a dental office would need to receive an advance directive from a dental patient? His is not common practice for dental care	1. Recipients over 21 are **NOT** eligible for this program. 2. DHH will review the requirements for advance directive.
7	DentaQuest	RFP	2.4.2.4	Workers' Compensation Insurance	8	Can DHH please clarify if there is a deductible for the Medicaid Dental Program?	The deductible reference in this section is the deductible that the responsibility of the Health Plan, not of any Medicaid member.
8	DentaQuest	RFP	3.2.1	Excluded DBP Population	10	The age of the covered population outlined In this section contradicts several sections that imply adults are covered, including sections 2.1, 2.3.5, 7.8.2, 23.38.	Medicaid recipients under 21 years of age are eligible for services specified in this RFP. Those that are ages 19-21 are considered adult individuals.

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9	DentaQuest	RFP	4.1.7.1	Additional Staff Required	14	Can DHH please confirm that it intended to include this requirement? Because providers can treat patients in an emergency without a prior approval, we are not sure why this requirement would pertain to a dental program.	Yes, DHH can confirm it intended to include this requirement and believes that the Health Plan should utilize all tools available to control utilization.
10	DentaQuest	RFP	6.4.14	Emergency Dental Services	24	Can DHH please clarify if it will be evalutation medical codes for dental procedures? How will the dental vendor know what ER utilization is? We would need this information in order to address the issue so we can avoid corrective action	DHH will provide the Health Plan historical claims related to dental on a weekly basis. DHH also excepts the dental Health Plan to coordinate with the other Bayou Health Plans on a regular basis to case management the care of their members.
11	DentaQuest	RFP	6.8.4	Expanded Servies/Benefits	25	Section 6.8.4 contradicts section 7.1.13.5 which states: If the Health Plan is unable to meet the geographic access standards for a member, the Health Plan must make transportation available to the member, regardless of wheter the member has acces to transportation. The Health Plan may be subject to sanctions for inablility to met the geographic access standards set forth in this RFP. Dental vendors do not typically coordinate travel for members.	This section of the RFP is regarding "expanded services" which are non-covered services in the Louisiana Medicaid State Plan. Section 7.1.13.5 references covered core benefits and services.
12	DentaQuest	RFP	6.9.1	Care Mangement	25	These two requirements imply that there would be more than one dental vendor. Can DHH please clarify	It is the intent of DHH to contract with one (1) vendor for the Dental Benefit Program.
13	DentaQuest	RFP	7.3	Access Standards and Guidelines	29	Can DHH please elaborate on the terms 'professional,' allied" and "para-medical" personnel and how it relates to the dental contract.	Professional personnel would consist of, but not limit to, dentists, doctors, etc. Allied personnel would consist of , but not limit to, dental assistants, dental hygienist, etc. Para-Medical personnel would provide services in an emergency situation. Definitions have been added to the glossary in Addendum #4.
14	DentaQuest	RFP	7.5.1	Timely Access	30	For dental services, providers are typically given 24 hours to schedule an appointment for a member experiencing a dental emergency. Can DHH please confirm this is the requirement for the dental program	DHH can confirm 7.5.1 is DHH's requirement.

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15	DentaQuest	RFP	7.5.3	Timely Access	30	Can DHH please elaborate on how the dental vendor will know what follow-up visits are needed as a result of a member visiting the ER?	See Section 6.9 Care Management stating all members should have "...a person or entity formally designated as primarily responsible for coordinating the dental health care services furnished to the member." and Section 7.13 Coordination with Other Service Providers which state "The Health Plan shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members".
16	DentaQuest	RFP	7.5.10	Timely Access	30	This requirement seems to pertain to medical . Can DHH pleas confirm this is a dental program requirements and provide an example of such a facility in existence today in Louisiana.	Yes, DHH can confirm it intended to include this requirement and believes that the Health Plan should utilize all tools available to control utilization.
17	DentaQuest	RFP	7.5.11	Timely Access	31	Dental vendors are typically not required to coordinate transportation. Can DHH please confirm that transportation coordination would be delegated to the dental vendor.	7.5.11 is requiring the Health Plan to establish processes to monitor and and reduce the appointment “no-show” rate for primary care dentists, and transportation providers. It does not require transportation coordination to be delegated to the Health Plan.

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18	DentaQuest	RFP	7.8.3	Access to Specialty Providers	32	If the dental vendor has difficulty contracting with certain specialties such as prosthodontists, periodontist, and endodontist, can the vendor have a list of general dentist that can perform these specialty services?	Per Section 7.1.1 of the RFP, "The Health Plan must maintain a network of qualified dental providers in sufficient numbers and locations to provide required access to covered services." "The Health Plan shall design its dental provider network to maximize the availability of community based primary dental care and specialty dental care access." Per 7.1.2 "The Health Plan must provide a comprehensive network to ensure its membership has access at least equal to, or better than, community norms. Services shall be accessible to Health Plan members in terms of timeliness, amount, duration and scope as those are available to Medicaid recipients who are not enrolled in the Dental Benefit Program [42 CFR §438.210(a)(2)].The Health Plan is encouraged to have available non-emergent after-hours primary dental care services within its network. If the network is unable to provide medically necessary services required under contract, the Health Plan shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. The Health Plan shall ensure coordination
19	DentaQuest	RFP	7.14.2	Subcontractor Requirements	36	Can DHH confirm it intends to only select one health plan to administer the statewide dental program? If not, is DHH considering two or more than two? If two or more dental health plans are awarded the contract and a provider choses to contract with us and not the other Health Plan, is the provider not allowed to participate in the dental program? Are providers required to contract with all Health Plans for dental if multiple health plans are awarded a contract?	It is the intent of DHH to contract with one (1) vendor for the Dental Benefit Program.
20	DentaQuest	RFP	7.14.4	Subcontractor Requirements	36	Laboratory services are typically paid for under the medical program. Can DHH please clarify if the dental health plan would be required to pay for laboratory services and under what circumstances?	See Section 6.2.1. The Health Plan shall be responsible for all Lab and X-ray services performed in the dental office/facility to meet a members dental needs. If outside the dental office/ facility and the member is in a Prepaid/Shared Health Plan, the network provider shall obtain approval of the member's Bayou Health Prepaid/Shared plan for all services provided.

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21	DentaQuest	RFP	8.7.3.2	Primary Care Dentist Utilization and Quality Profiling	45	Can DHH please confirm this is a requirement for the dental program? DHH or member's health plan would need to provide this information to DentalQuest as we do not process medical claims.	Yes, DHH can confirm this is a requirement. See Section 7.13. Coordination with Other Service Providers states "The Health Plan shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members." The Health Plan will be required to have a procedure in place to track emergency department ***referrals*** by the primary care dentist.
22	DentaQuest	RFP	8.7.3.3	Primary Care Dentist Utilization and Quality Profiling	45	This information may be collected by the dentist as necessary. Dental vendors are typically not required to maintain this information. Can DHH please confirm if this is a requirement for the dental program?	Yes, DHH can confirm it is a requirement. This information should be maintained by the dental vendor to provide feedback to the primary care dental provider for education/outreach to the member for future services.
23	DentaQuest	RFP	9.7.1.6	Payment for Emergency Services	48	The member's health plan typically pays for and coordinates transportation. Is transportation required as part of the dental contract?	Yes, DHH is confirming it is a requirement.
24	DentaQuest	RFP	10.1.1	Provider Relations	49	Providers can treat members in need of emergent dental needs with no prior authorization. Can DHH please elaborate on the necessity of this requirement?	Please see Addendum #4 for clarification.
25	DentaQuest	RFP	10.1.4	Provider Relations	49	Providers can treat members in need of emergent dental needs with no prior authorization. Can DHH please elaborate on the necessity of this requirement?	10.1.4 is not relative to the question being asked.
26	DentaQuest	RFP	12.5.2.18	Health Plan Member Handbook	64	The member's health plan typically pays for and coordinates transportation. Is transportation required as part of the dental contract?	Yes. The Health Plan is responsible for transportation in emergency situation and in instances where the Health Plan is unable to meet the geogrpahic access standards as defined in Section 7.1.13.5 of the RFP.
27	DentaQuest	RFP	12.7.4.2	Provider Directory for Members	65	Can you please provide an example of a "hospital primary care dentist group" in DHH of Louisiana. We are not familiar with any such facility.	Children's Hospital Dental Clinic, New Orleans, LA.

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28	DentaQuest	RFP	12.11	Additional Educational Materials and Programs	69	Dental vendors typically do not send member newsletters. We frequently write articles for inclusion in the health plan's members newsletter. Please confirm that DHH is expecting the dental vendor to create dental-only newsletters.	Yes, DHH is confirming it is a requirement to prepare and distribute educational materials to its members.
29	DentaQuest	RFP	12.12.1	Oral and Written Interpretation Services	69	This function is typically paid for by the dental provider or the member's health plan. Please confirm that the dental vendor will be expected to pay for and coordinate interpreter services for the members.	Yes, DHH is confirming this is a requirement.
30	DentaQuest	RFP	14.4.2	Member Satisfactory Survey	82	Dental vendors do not perform these surveys, as they are related to medical care. We do conduct a member survey that meets NCQA requirements and asks similar questions to CAHPS surveys.	DHH cannot respond without comparing the survey mentioned to the CAHPS surveys. The proposer may provide the name of an alternative survey in their response and DHH will take it under consideration.
31	DentaQuest	RFP	1.2.3	Purpose of RFP	1	What are the HEDIS goals or percentage the health plan would be measured against?	Appendix T - 2011 Medicaid NCQA Quality Compass at or below the 50thPercentile.
32	DentaQuest	RFP	2.1	Requirements of Health Plan	5	How many members are CHIP?	Current CHIP enrollment under 21 is approximately 120,522. However, there is no difference in benefits or services members are eligible to receive whether certified under LaCHIP or in another Medicaid eligibility category.
33	DentaQuest	RFP	2.1	Requirements of Health Plan	5	How many members are Medicaid?	Current Medicaid enrollment under 21 (excludes CHIP) is approximately 619,841. However, there is no difference in benefits or services members are eligible to receive whether certified under LaCHIP or in another Medicaid eligibility category.
34	DentaQuest	RFP	2.1	Requirements of Health Plan	5	Are the benefits the same for CHIP and Medicaid? If not where do we find the CHIP benefits?	Benefits are the same for all members.
35	DentaQuest	RFP	2.1	Requirements of Health Plan	5	Please confirm only children under 21 are covered.	Yes, DHH can confirm eligible Medicaid recipients under 21 years of age are eligible for services under the Bayou Health Dental Program.

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36	DentaQuest	RFP	2.1	Requirements of Health Plan	5	Are pregnant women covered? If yet what is the membership and benefits?	Yes, DHH can confirm eligible pregnant women under the age of 21 are eligible for services under the Bayou Health Dental Program. DHH can not identify the pregnant women as there is not a separate eligibility category. Pregnant women receive the same covered services as CHIP Medicaid/LaCHIP recipients.
37	DentaQuest	RFP	2.2.2	DBP Project Overview	6	Can DHH please confirm that its intention was to only issue an 11 month contract?	Yes. The first contract year will consist of 11 months. Upon successful performance, the state shall have (2) 12 month options for renewal beginning February 1 of each year.
38	DentaQuest	RFP	3.2.1	Excluded DBP Population	10	Can DHH please confirm that this program is just for members under 21?	Yes, DHH can confirm eligible Medicaid recipients under 21 years of age are eligible for services under the Bayou Health Dental Program.
39	DentaQuest	RFP	7.8.2	Access to Specialty Providers	32	Can DHH please confirm that this program is just for members under 21?	Yes, DHH can confirm eligible Medicaid recipients under 21 years of age are eligible for services under the Bayou Health Dental Program.
40	DentaQuest	RFP	23.38	Provider Incentive Plans	151	Are Medicare members part of the program? If not, will the dental vendor have to comply with Medicare requirements?	1. No. 2. Yes.
41	DentaQuest	Appendix AA	26	Proposal Submission and Evaluation Documents	63	Please provide Appendix KK. This was not posted to the website.	Addendum #3 has been issued to correct the incorrect reference. Appendix KK is now Attachment E.
42	DentaQuest	Appendix AA	26	Proposal Submission and Evaluation Documents	46-47	Total points listed as 25 but the 2 questions in this section only total 15 point. Can DHH please clarify the total points for Section L?	Addendum #3 has been issued to correct the error. Total points of Section L is 15. See revised Appendix AA on the www.makingmedicaidbetter.com website.
43	DentaQuest	RFP	27	Systems Companion Guide	2	Can DHH please provide what is missing from the sentences?	Encounter services include core benefits and services to Medicaid members based on their eligibility groups as specified by DHH in Section 3 of the RFP for the eligibility groups.

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44	DentaQuest	RFP	27	Systems Companion Guide	4	Can DHH please clarify what type of edits will be run on the encounter data and reported on the weekly report?	Encounters edits are being defined by DHH and Molina and will be published in a later version of the SCG. Basic encounter edits include (but are not limited to): valid recipient, and recipient is eligible on DOS; valid billing provider, and provider is enrolled with plan on DOS; valid servicing provider, and provider is enrolled with plan on DOS; valid service units; valid billed charges and billed units; valid dental service; valid dental service, and dental service was prior authorized by plan, if appropriate; valid tooth modifier(s), when appropriate; recipient is under 21 years of age on DOS; Health Plan included payment information and payment date information on encounter.
45	DentaQuest	RFP	27	Systems Companion Guide	4	Can DHH please clarify the use of file format 820?	The 820 file format is a HIPAA X12N v5010 standard for communicating PMPM payments information between the FI and the Health Plan. It will be used as the principal data reporting mechanism of detail PMPM payments from the FI to the Health Plan.
46	DentaQuest	RFP	27	Systems Companion Guide	6	Can DHH please clarify the use of the 837I for use with dental claim reporting. 837I is not normally apply to dental?	837I is identified for plan reference only; we recognize that it is not to be used for dental services encounters submissions.
47	DentaQuest	RFP	27	Systems Companion Guide	7	Can DHH please clarify the cases that DHH would expect the dental vendor to submit more than the weekly encounter file?	The FI processes encounters on a weekly basis, but the Plan may submit encounters on a daily basis, with a limitation of 99 files per day.

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48	DentaQuest	RFP	27	Systems Companion Guide	7	Can DHH please clarify who is responsible for generating the ICN?	The Plan must establish in their claims processing application, the creation of a claim Internal Control Number (ICN) that uniquely identifies a claim line service. The Plan's claim ICN must be submitted on the encounter to the FI. The FI also creates an ICN, unique to the FI, for each encounter line received by the FI. So, there are two ICNs: the Plan's ICN and the FI's ICN. DHH must be furnished with the Plan's ICN format.
49	DentaQuest	RFP	27	Systems Companion Guide	8-9	Can DHH please clarify how this section *Category II CPT codes* applies to the administration and reporting of dental claims. CPT, HCPCS, PARI QDCs and diagnosis pointers are usually applied to medical claims?	This information is provided for the plan's reference; we recognize that CPT and HCPCS are not used for dental services. Nevertheless, in the case of NEMT services, the plan should stipulate the use of correct procedures.
50	DentaQuest	RFP	27	Systems Companion Guide	9-10	Can DHH please clarify the use of the 837I and 837P to the administration and reporting of the dental program?	We recognize that 837I will not be used at this time. 837P will be used to report NEMT services.
51	DentaQuest	RFP	27	Systems Companion Guide	9-13	Can DHH clarify the provider types to be used for 837D?	See the latest version of the Systems Companion Guide.
52	DentaQuest	RFP	27	Systems Companion Guide	25-27	Can DHH please clarify if the vendor or the FI is responsible for paying the claims?	The Health Plan is responsible for paying provider claims, not the FI.
53	DentaQuest	RFP	27	Systems Companion Guide	26-27	Can DHH please clarify what types of payment reductions can be made by MMIS/FI as reflected back to the Health Plan on the 835?	This information is not appropriate to the DBP.
54	DentaQuest	RFP	27	Systems Companion Guide	27	If the lines fails, we reprocess the whole claim. Can HDD please clarify if this would be acceptable, or if it only wants the rejected services re-submitted to DHH?	Only the lines that fail.
55	DentaQuest	RFP	27	Systems Companion Guide	34	Can DHH please clarify if Atypical providers will be allowed to provide dental service to DHH members?	Atypical providers will not be allowed to provide dental services; but many NEMT providers are atypical.
56	DentaQuest	RFP	27	Systems Companion Guide	53	Can DHH please clarify how the following codes are applicable to administration of the dental program: ICD-9, National Drug codes (C+NDC), HCPCS, CPT?	ICD-9s may or may not be applicable to dental services; NDCs are not applicable; HCPCS are not applicable; CPT are applicable to NEMT services.
57	DentaQuest	RFP	27	Systems Companion Guide	53	Can DHH please clarify if the reference to ICD-9 should be ICD-10?	ICD-9 is correct.

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58	DentaQuest	RFP	27	Systems Companion Guide	53	Please clarify if the CDT code sets are to be used for the administration of dental?	Yes, CDT code sets are to be used for the administration of dental services. Refer to the DHH Louisiana Medicaid FFS Dental Fee Schedule for current codes in use in the FFS program.
59	DentaQuest	RFP	27	Systems Companion Guide	56	Please clarify the definition of TCNs.	TCN=Transaction Control number; it is a number uniquely assigned to an encounter that appears on the 835 file.
60	DentaQuest	RFP	27	Systems Companion Guide	58 and 61	Please clarify when the "later version" will be available. We can not determine if there are any issues with the format until we get the final version.	It is anticipated that the 'later version' will be included in the next revision of the SCG, due out the first week in January.
61	DentaQuest	RFP	27	Systems Companion Guide	59 and 62	Can DHH clarify why there are two dental claim types (10 and 11)	Presently in the FFS program, DHH uses two claim types for dental services: 10=EPSDT Dental and 11=Adult Dental.
62	DentaQuest	RFP	27	Systems Companion Guide	73	Please clarify how the dental vendor is expected to use the MMIS assigned provider id, where does it originate.	The FI is responsible for enrolling dental providers who wish to participate in the FFS Medicaid program. When a dental provider enrolls with the FI, the FI issues a unique legacy Medicaid ID number to the provider, that is cross-walked to the provider's NPI. The legacy ID will be sent to the Health Plan as part of the provider information sent by the FI. These numbers will be useful to the Health Plan when corresponding with the FI regarding provider issues.
63	DentaQuest	RFP	27	Systems Companion Guide	73	Please clarify who owns the provider data, does it originate from the dental vendor since it would be responsible for contracting.	DHH owns the provider data, including any obtained by the Health Plan in the performance of this contract; and provider data established by the FI.
64	DentaQuest	RFP	27	Systems Companion Guide	81	Please clarify the use of the 820 file - the file format is defined as "EDI Payroll Deducted and other group Premium Payment for Insurance Products." How does this apply to the administration of the dental program?	See response to Question # 45.
65	DentaQuest	RFP	27	Systems Companion Guide	91	Can DHH please clarify how the Diagnosis file for Pre-Admission Certification applies to the administration of the dental program?	The Health Plan may ignore or use this information as they see fit.
66	DentaQuest	RFP	27	Systems Companion Guide	94	Can DHH please clarify how the Diagnosis file CLIA applies to the administration of the dental program?	This information was removed from the latest SCG.

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67	DentaQuest	RFP	27	Systems Companion Guide	98	On page 26, "Service Line" indicates that a full list of encounter edits are contained in the Appendix F. We do not find a list of encounter edits in Appendix F. Please describe and detail the exact edits that DHH will be doing on the service included in 837 file. Please clarify the difference between the dental vendor editing of the claims and the DHH edits.	See response to Question # 44.
68	DentaQuest	RFP	27	Systems Companion Guide	98	Please clarify when the table indicated will be available.	See response to Question # 44.
69	DentaQuest	RFP	27	Systems Companion Guide	130-131	Please clarify how the Types of Service are to be used for CCN Entities as it pertains to the administration of the dental program.	This information is provided for the plan's reference. It is an important item in the FI's MMIS system and can occur in discussions with DHH and the FI. Also, it may appear in the fee schedule information; so the Health Plan should be aware of it.
70	DentaQuest	RFP	27	Systems Companion Guide	132	Please clarify how the Category of Service are to be used for CCN Entities as it pertains to the administration of the dental program.	See response to Question # 69.
71	DentaQuest	RFP	27	Systems Companion Guide	135	Please provide how the Provider Specialty list are to be used for the administration of the dental program. Many of the specialist listed do not pertain to dental.	See response to Question # 69.
72	DentaQuest	RFP	27	Systems Companion Guide	140	Please clarify how the Pricing Action Code (PAC) listed are to be used in the administration of the dental program. The PAC list includes medical.	The information on dental PAC codes is updated in the latest version of the SCG. Also, see response to Question # 69.
73	DentaQuest	RFP	27	Systems Companion Guide	145	Please clarify how the these codes are to be used, Do they have to be shown to provider with the member's eligibility? Which aid categories pertain to the dental program.	This is important information for the Health Plan because it can be used to differentiate Title XVIII, Title XIX and Title XXI enrollees. They do not need to be shown to providers. Potentially all aid categories pertain to the dental program. The Health Plan should become very familiar with this information.
74	DentaQuest	RFP	27	Systems Companion Guide	144	Please clarify how the Scopes of Coverage list is used in administration to the dental program.	Scopes of Coverage are useful in Other Payer and Third-Party Liability situations. A sizeable portion of recipients have TPL, and some of them have dental coverage. The Health Plan should become very familiar with this information.

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75	DentaQuest	RFP	27	Systems Companion Guide	144	Please clarify how the Recipient Type Case Codes list is used in the administration of the dental program.	See response to Question # 73.
76	DentaQuest	RFP	16.2.3	HIPPA Standard and Code sets	90	The 837I, 837P, and 820 files are not usually used in the administration of Dental file exchanges - please clarify why this is included in the HIPPA information exchange list.	See response to Question # 50 relative to the 837I and 837P, and Question # 45 relative to the 820.
77	DentaQuest	RFP	16.5.2.2	Resource Availability and System Changes	91	Manuals for systems available for DHH use will include manuals, systems that are proprietary will not be available to DHH>	DHH requires additional specificity to be able to answer this question.
78	DentaQuest	RFP	16.5.2.7	Rescource Availability and System Changes	94	Please clarify the format that DHH requires for Systems Quality Assurance Plan	The Systems Quality Assurance Plan should be submitted in a 'Word' document format.
79	DentaQuest	RFP	16.11.2	Infromation Systems Availablity	96	Access to our systems and data will be granted as it is approved by our legal department. We would find other ways of providing the same resources if necessary.	The Health Plan shall comply with Section 16.11.3.
80	DentaQuest	Appendix AA	26	Proposal Submission and Evaluation Documents	42	The Dental Benefit Program Health Plan will not provide members with a separate ID card." Is the dental vendor required to send ID cards to eligble members?	No. The Health Plan is NOT responsible for providing members with separate health cards. An addendum is being issued to clarify this issue.
81	DentaQuest	Appendix AA	26	Proposal Submission and Evaluation Documents	62	Is the information in Attachment A everything we need to research vendors for the Veteran Hudson initiative? Please provide Appendix JJ. It was not placed on the website.	Addendum #3 has been issued to correct the incorrect reference. Appendix JJ is now Attachment A. See revised Appendix JJ on the www.makingmedicaidbetter.com website.
82	DentaQuest	RFP	11.2.3	Enrollment Procedures	55	When a member calls customer service and we verify his/her address and it is different from what cam in the eligibilty file from DHH are we requiredto notify the State of this discrepancy?	Yes, see Section 16.9.3.
83	DentaQuest	RFP	11.2.4.2	Enrollment Procedures	56	Does the member welcome packet, which would include information on changing the primary care denist assignment satisfy the requirement?	No. The Health Plan is responsible for contacting the member to assist with primary care dentist selection in addition to sending the welcome packet.

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84	DentaQuest	Finacial Reporting Guide	2.01		6	Is this quaterly reporting to be done for onlyt eh Louisiana contract and is it to be done on a GAAP basis	Please refer to the Financial Reporting Guide Instructions, Section 1.03 General instructions, which states: 1) "Amounts reported to DHH under this Guide are to represent only covered services for recipients eligible for the Bayou Health Program"; and 2) "Generally accepted accounting principles (GAAP) are to be observed in the preparation of these reports. Specifically, all revenues and expenses must be reported using the accrual basis method of accounting."
85	DentaQuest	Finacial Reporting Guide	3.01		19	Can you please elobrate on DHH's definition of the "parent company" ?	The parent company is the same company you will be providing information on in your proposal (Appendix AA, Part II, Section B).
86	UnitedHealthcare Insurance Company Larry Cavanaugh	RFP	21.21	Announcement of Award	139	How many carriers will be awarded this dental contract?	It is the intent of DHH to contract with one (1) vendor for the Dental Benefit Program.
87	UnitedHealthcare Insurance Company Larry Cavanaugh	RFP	2.1	Requirements of Health Plan	5	If a carrier is currently contracting for the BayouHealth medical, can the same carrier submit a proposal for the dental with violating Section 2.1 #5 (conflict of interest)?	Bayou Health is requesting a legal opinion from our Bureau of Legal Services, and will post the response to the www.makingmedicaidbetter.com website.

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88	UnitedHealthcare Insurance Company Larry Cavanaugh	RFP	21.10.3	Procurement Library/Resources Available to Proposer	135	Will the DHH provide the following data? For Claims, we'd like the following information: - Incurred month - Member by county - Member Identifier (number) - Member age - Benefit code (if there are multiple benefits) - ADA code - Units - Paid Dollars *We'd like the most recent 36 months of data that is available For membership, we'd like the following information: - Month of service - Member by county - Member age - Benefit code (if there are multiple benefits) - Member months *We'd like the most recent 36 months of data that is available; and consistent with the claims data	See Appendix H - Health Plan Data Use Agreement for details on the data that will be provided.
89	Dr. Gregory J. Folse	RFP	7.1	General Provider Network Requirements	26	While the RFP creates an obligation for the Health Plan "to maintain a network of qualified dental providers in sufficient numbers and locations to provide required access to covered services," it is silent regarding models of care. In Louisiana, school based mobile dentistry is an approved model of care that has increased access to dental services for the DBP eligible population. Does the Health Plan have an obligation to make a "good faith effort" to execute a contract with school based mobile dental providers?	Per Section 7.10 of the RFP states: The Health Plan should make a good faith effort to include in its network, primary care dentists and specialist who are significant traditional providers (STPs) provided that the STP: • Agrees to participate as an in-network provider and abide by the provisions of the provider contract; and • Meets the credentialing requirements.

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90	Dr. Gregory J. Folse	RFP	7.1.6	General Provider Network Requirements	26	Section 7.1.6 references the term significant traditional providers (STP); a term that is defined in the RFP glossary as "those Medicaid enrolled providers that provided the top 80% of Medicaid services for the DBP-eligible population in the base year of 2010. In 2010, 2011, and 2012 my practice has treated 11,694, 16,271, and 16,533 DBP Eligible children respectively. Given my practice's numbers, do I qualify as an STP as defined by the RFP?	This list has been posted on the www.makingmedicaidbetter.com website under RFP - Dental Benefit Program Procurement Library at http://www.dhh.louisiana.gov/index.cfm/page/1511
91	Dr. Gregory J. Folse	RFP	11.3.6 and 11.3.7	Primary Care Dentist Auto Assignment	56	Section 11.3.6 states, in part, that "the Health Plan shall allow the member to change primary care dentist." However; Section 11.3.7 appears to limit the member's ability to change primary care dentists by providing the Health Plan with the authority to grant the request: "the Health plan may agree to grant this request for good cause." If the member makes the request to change primary care dentists does the Health Plan have the authority to deny the member's good faith request?	Yes, however a Health Plan must allow a member to change for cause. (i.e. the member moves out of a provider's service area)
92	Dr. Gregory J. Folse	RFP	11.3.6	Primary Care Dentist Auto Assignment	56	Section 11.3.6 appears to provide the member the ability to select their primary care dentist. If a member is auto assigned a primary care dentist, but his or her parent/guardian determines at a later date that a school based mobile provider is their primary care dentist of choice will the member be able to change his or her primary care dentist? Does the Heath Plan have the discretion to deny the member's good faith request without cause?	The Health Plan has the authority to establish their own PC dentist assignment policy and procedures.
93	DentaQuest	Dental Services Manual				Can the Health Plan add or delete this requirement on a per code basis?	Yes, pending approval from DHH.
94	DentaQuest	Dental Services Manual	16.1		1	For the oral cavity designators, are we required to use only numbers or can we also accept UR, UL, etc.?	Yes, as long as it follows the ADA Dental Claim Form completion instructions.

Question #	Submitter Name	Document Reference	Section Number	Section Heading	Page Number in Referenced Document	Question	DHH Response
95	DentaQuest	Dental Services Manual	16.5		1	This section seems to imply that prior authorizations are required for some services. However, section 16.7 page 1 appears to indicate prior authorization is only needed prior to payment, which is essentially pre-payment review. Can DHH please clarify the requirement related to prior authorizations and pre-payment review?	Procedure codes for services requiring PA are marked with an asterisk (*) and must be authorized before payment will be made. The appropriate x-rays that support the clinical findings and justify the treatment are also required. Procedure codes that require prior authorization, must have an approved decision before payment can be made.
96	DentaQuest	Dental Services Manual	16.5		43	Is the Health Plan restricted to this payment methodology?	No, however all changes but be prior approved by DHH in writing.
97	DentaQuest	Dental Services Manual	Appendix A		2	Will the Health Plan be required to maintain these fees or can it make strategic adjustments to limit the misuse of selected codes?	The Health Plan rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on date of service, unless DHH has granted an exception for a provider- initiated alternative payment arrangement.
98	DentaQuest	RFP	1.2.3	Purpose of RFP	1	Does the Louisiana Medicaid population have a high instance of being admitted to the hospital for dental issues? If so, can DHH please provide data on this?	The Health Plan will be provided historical claims data to make an independent evaluation on this issue.
99	DentaQuest	RFP	2.4.2.4	Insurance Requirement	8	We understand that is applicable for network providers, but would other subcontractors/vendors such as printing/scanning companies also need to comply with this requirement?	Unless, the subcontractor meets the definition as defined in the glossary, no.
100	DentaQuest	RFP	4.1.6.2	Key Staff Positions	11	This references medical staff. Did DHH intend to say medical or dental? If we are to use dental staff, do the dentists have to be licensed?	1. 4.1.6.2 is referencing dental staff. 2. All dental staff must be licensed and credentialed.
101	DentaQuest	RFP	4.1.6.9	Key Staff Positions	12	In our experience, dental health plans do not employ medical management coordinators. The job description encompasses the responsibilities of a dental director and a quality management coordinator. Can DHH please confirm that the health plan is required to have a medical management coordinator?	The health plan is required to have a Medical Management Coordinator.
102	DentaQuest	RFP	4.1.6.10	Key Staff Positions	13	DHH is using the word "member." Was it DHH's intent to use the term "provider" in this requirement?	Language will be revised in Addendum #4 to clarify.

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103	DentaQuest	RFP	4.2	In-State Positions	14	We appreciate that DHH wishes to maximize program oversight by asking its dental vendor to establish a strong local presence, and we agree with this premise. However we ask that DHH consider the costs involved by requesting such a broad local team. We submit that strong program oversight can be accomplished with a smaller local team, and we base this assertion on the statewide Medicaid programs we administer in 10 states - the most of any dental vendor in the nation. In each market we determine an ideal staffing model based on the size and scope of the dental program, adding to it as needed to accommodate program growth. We are confident that we can oversee the success of the Bayou Health Dental Benefit Program with less staff than requested, thereby reducing the overall cost of the program. Would DHH consider easing its requirement that all 9 positions be established in Louisiana - not more than two occupied by an individual staff member (reference to Section 4.1.1) – permitting these positions to be filled by both in- and out-of-state staff?	Due to the investment the State of Louisiana is making into the Program, DHH believes it is important for the Health Plan to also demonstrate its commitment through establishing a "strong local presence" here in the State of Louisiana.
104	DentaQuest	RFP	4.3.1	Written Polices, Procedures, and Job Descriptions	14	DHH's references "medical director." Is this applicable to the dental contract? Can policies be approved by a chief operating officer?	As specified, in 4.3.1, all medical and quality management policies must be approved and signed by the Health Plan's Medical Director.
105	DentaQuest	RFP	5.3	Rate Adjustments	16	Will the Health Plan have the right to present rate considerations in the future or during annual renewal periods?	In the cases where DHH renegotiates the PMPM rates or at annual contract review, the Health Plans may be requested to submit their proposed rates.
106	DentaQuest	RFP	5.7.2.3	Third Party Liability (TPL)	18	Should the term "medical treatment" be replaced with "dental treatment"?	Medical treatment associated with dental services.
107	DentaQuest	RFP	5.7.3.2	Third Party Liability (TPL)	18	Health plans for dental services process CDT codes. The codes listed in this section are relevant to medical, not dental. Can DHH please clarify this requirement?	The CPT codes may not be applicable to dental services however, this requirement is for the contractor to identify services that are related to accident or incident.
108	DentaQuest	RFP	5.7.3.4	Third Party Liability (TPL)	18	Can DHH please clarify this requirement as it pertains to the dental program?	Dental services that are rendered due to an accident or incident where the aggregate claim amount is $500 or greater.

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109	DentaQuest	RFP	5.7.3.3	Third Party Liability (TPL)	18	Is this requirement related to Section 5.7.3.2? If so, we do not believe this would be applicable to dental. Can DHH please clarify?	This requirement is to report any other dental insurance that a Medicaid member has.
110	DentaQuest	RFP				Hospitals typically do not employ dentists on staff or in the ER. In our experience, the role of an ER doctor is to help alleviate the member's pain and sometimes prescribe an antibiotic or pain medication. They would then advise the member to make a dental appointment. Can DHH please clarify this requirement?	More specificity is required to answer this question.
111	DentaQuest	RFP	6.4.4	Emergency Dental Services	23	Can DHH please clarify if it will be evaluating medical codes for dental procedures?	Yes, DHH will be evaluating medical codes for dental procedures.
112	DentaQuest	RFP	6.5.1	Dental Services for Special Populations	24	Will DHH supply an indicator or flag on the eligibility files for noting patients with special needs?	No, the indication of special needs patients are the responsibility of the Health Plan.
113	DentaQuest	RFP	7.1.2	Material Change to Provider Network	26	Can DHH please provide its definition of “community norms”? Are their specific “community norms” that health plans must meet?	1. Community Norms are defined as services and/or accessibility to services that members are accustom to in their geographic area. 2. The Health Plan must provide a network that is sufficient to provide core benefits and services within designated time and distance limits.
114	DentaQuest	RFP	7.1.6	Material Change to Provider Network	26	We are inviting all of the STPs to our network. Can we do so at standard rates or are we required to pay what DHH paid in the past if they were on a special deal?	The Health Plan rate of reimbursement shall be no less than the published Medicaid fee-for-service rate, however the Health Plan does have the flexibility to pay a rate greater than the current fee for service rate.

Question #	Submitter Name	Document Reference	Section Number	Section Heading	Page Number in Referenced Document	Question	DHH Response
115	DentaQuest	RFP	7.5.3	Timely Access	30	Can DHH please define the term "non-urgent sick care" as it relates to dental? It is defined in the glossary as "medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non-urgent sick visit include cold symptoms, sore throat, and nasal congestion; requires face-to-face medical attention within 48-72 hours of member notification of a non-urgent condition, as clinically indicated." This is not a term used in dentistry. Typically there is emergency, urgent and routine care.	This would be considered the same as the non-emergency urgent dental needs which would include but not be limited to: tooth ache relief, swollen jaw relief and sore gum relief.
116	DentaQuest	RFP	7.3	Access Standards and Guideleens	29	Is the health plan permitted to pay more than Medicaid rates to an out of network provider?	Yes.
117	DentaQuest	RFP	7.6.1	Assurance of Adequate Primary Care Dentist Access and Capicity	31	Federal requirement is typically one member per 1500 PCDs. Can DHH please confirm it wishes to have a ratio of one member per 5000 PCDs?	DHH is not aware of the Federal requirement of 1500:1. Per the information DHH has available the maximum ratio is 3,000 recipients to 1 Dentist. This clarification is being updated in Addendum #4.
118	DentaQuest	RFP	7.6.2	Assurance of Adequate Primary Care Dentist Access and Capicity	31	Will a 24-hour answering service with direction for care sufficiently meet this requirement?	No, not if it is a substitute for the extended hours.
119	DentaQuest	RFP	7.6.3	Assurance of Adequate Primary Care Dentist Access and Capicity	31	Can DHH please clarify this requirement? It was our understanding that all members under FFS were going to be covered under the statewide dental carve out.	No, not all recipients will be under this Program. Recipients over 21 will not be in the Bayou Health Dental Program and recipients who may require dental services prior to being enrolled into the Bayou Health Dental Program may receive services under fee-for-service.
120	DentaQuest	RFP	7.6.3	Assurance of Adequate Primary Care Dentist Access and Capicity	31	Can DHH confirm that this requirement is for the dental Health Plan to coordinate care with the member's medical plan?	7.6.3 does not reference coordination of care.

Question #	Submitter Name	Document Reference	Section Number	Section Heading	Page Number in Referenced Document	Question	DHH Response
121	DentaQuest	RFP	7.11.2	Provider Network Development Management Plan	32	Will the Health Plan have to pay for a second evaluation if one was already performed by a PCD? How does this affect the frequency requirement for covered code exams for dental?	The Health Plan's utilization management plan should address this issue.
122	DentaQuest	RFP	8.1.2	Genreal Requirements	38	Can DHH define what is applicable to dental vs. medical in UM requirements?.	All requirements specified in 8.1.2 are applicable.
123	DentaQuest	RFP	8.7.3.2	Primary Care Dentist Utilization and Quality Profiling	45	Can DHH please confirm this is a requirement for the dental program? How do we access emergency department utilization? Will DHH provide this data? DHH or member's medical Health Plan would need to provide this data to us since we do not process medical claims.	Yes, DHH can confirm this is a requirement. DHH will provide claims information to the Health Plan on a weekly basis.
124	DentaQuest	RFP	8.7.3.3	Primary Care Dentist Utilization and Quality Profiling	45	Can DHH please confirm if this is a requirement for the dental program? How do we access hospital admits, lab, radiology and medication data? This information may be collected by the dentist as needed. Health Plans are typically not required to maintain this information.	Yes, DHH can confirm this is a requirement. DHH will provide claims information to the Health Plan on a weekly basis.
125	DentaQuest	RFP	9.1.1	Minimal Reimbursement to In-Network Providers	45	How often does DHH change the rates for the MA fee schedule and cost-based reimbursement (FQHC, etc.)?	DHH revises its rates as mandated by the legislature or as a result of federal or state budget reductions or increases. FQHCs/RHCs rates are updates at least annually.
126	DentaQuest	RFP	10.1.5	Provider Relations	50	Does this refer to provider relations education and touch points, or does this refer to a formal NCQA site visit requirement for credentialing, complaints or otherwise?	This refers to primary care dentist sites.
127	DentaQuest	RFP	10.2.2	Provider Toll Free Telephone Line	50	Does the reference "staffed" mean the Health Plan must have personnel in the office 24/7? Can DHH please define the term "complaint"?	1. After hours access can be staffed by a answering service. 2. Complaints shall be define as something that is unsatisfactory or unacceptable.
128	DentaQuest	RFP	10.6.2.7	Provider Complaint System	53	What type of venue or process must the Health Plan have for providers to present their case in person?	The Health Plan may define this venue or process.

Question #	Submitter Name	Document Reference	Section Number	Section Heading	Page Number in Referenced Document	Question	DHH Response
129	DentaQuest	RFP	11.2.2	Enrollment Procedures	54	Will these effective dates be provided on the eligibility file, or will they need to be derived during processing?	This information will be provided in the member file transmitted to the Health Plan by the Fiscal Intermediary.
130	DentaQuest	RFP	11.2.3	Enrollment Procedures	55	Does this include changes which are sent on the eligibility file?	No. Changes sent on the eligibility file have already been reported to DHH. The Health Plan is responsible for reporting information that differentiates from that which is reflected on the eligibility file.
131	DentaQuest	RFP	11.2.4.2	Enrollment Procedures	55	Please confirm if this will be a requirement for the dental program.	Yes, DHH is confirming it is a requirement.
132	DentaQuest	RFP	11.3.1	Primary Care Dentist Auto Assignment		Are there any payment restrictions if the member chooses to see a provider they are not assigned to?	The Health Plan may choose not to reimburse the provider.
133	DentaQuest	RFP	11.4	Disenrollment	56	Can DHH please advise where the format is specified?	There is no specified format for this report at this time. As noted in Appendix W, this report is "To Be Established."
134	DentaQuest	RFP	14.3.5.3	Performance Measures	81	Can DHH please explain why it would be necessary for a Health Plan to review medical records? We review dental provider charts as needed and as part of audits, but have not been required to conduct an annual review of medical records.	The annual audit would be of the dental provider charts which are considered the medical records of dental treatment.
135	DentaQuest	RFP	15.6.1	Medical Records	88	Will this record review be required of all providers who render treatment to Medicaid members and how often will these record reviews be required?	Yes, 15.6.1 is a requirement that policies and procedures are in place so that ***all providers/contractors*** are required to maintain service records in order that the health plan can validate reimbursement for services rendered.
136	DentaQuest	RFP	16.2.3	HIPAA Standard and Code Sets	90	The 837I, 837P and 820 files are not usually used in the administration of dental file exchanges. Can DHH please clarify why this is included in the HIPAA information exchange list?	This is a duplicate of Question # 76.
137	DentaQuest	RFP	16.3.8	Connectivity	91	Please clarify if the details in this section are medical or dental.	The details provided in 16.3.8 are based on our current FI Contract with Molina for all Medicaid Claims, which include Medical and Dental.
138	DentaQuest	RFP	16.5.2.2	Rescource Availability and System Changes	93	Manuals for systems available for DHH use will include manuals. Systems that are proprietary will not be available to DHH.	This is a duplicate of Question # 77.

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139	DentaQuest	RFP	16.5.2.7	Rescource Availability and System Changes	94	Please clarify the format that DHH requires for the Systems Quality Assurance Plan	This is a duplicate of Question # 78.
140	DentaQuest	RFP	16.9.3	Member Enrollment	95	Where can the formats and methods be found?	A Demographics website is utilized by existing DHH Contractors to update member information such as mailing address, phone number, etc. Access will be given to the DBP upon completion of a contract. This information will not be published in the Systems Companion Guide, but will be furnished to the Plan at a later date.
141	DentaQuest	RFP	20.3.3	Monetary Penalties	125	How will DHH measure network adequacy? Would it be according to quaterly GEO access reports?	Submission of provider registry (initially and weekly), initial and quarterly Geo reporting, secret shopper monitoring, and access to care complaints, grievance and appeals reporting and other ad hoc reporting as deemed necessary by DHH.
142	DentaQuest	RFP			154 and 158	In an instance when the Health Plan might find itself in a cost-prohibitive situation either due to an unexpectedly high increase in utilization, or in a case where DHH renegotiates the PMPM rates under the rights listed in Question 5.3, Rate Adjustments, will the Health Plan have the option to make price adjustments as referenced within the Cost Neutral Definition? Or, in the alternative, does the Health Plan have the right to opt out of the program?	The Health Plan cannot offer an amendment to the contract, only DHH can offer an amendment to the contract. DHH is expecting the Health Plans to control utilization. In the cases where DHH renegotiates the PMPM rates, the Health Plans may be requested to submit their proposed rates. The Health Plan does not have the right to opt out of the program without penalties. The Health Plan may chose to renew its contract at the end of each contract period.
143	MCNA					Are children covered under Special Children's Health Care Services included in the covered population?	Yes.
144	MCNA					Will the state be responsible for all claims, appeals, and hearings for dates of services prior to March 1, 2013?	Yes, DHH will be responsible for all claims, appeals and hearings for dates of services prior to implementation of the Program.
145	MCNA					Will the state be responsible for all services pursuant to a prior authorization issued by the state rather than the DBP?	The Health Plan may establish its own prior authorization requirements.

Question #	Submitter Name	Document Reference	Section Number	Section Heading	Page Number in Referenced Document	Question	DHH Response
146	MCNA					Prior to the release of the RFP, we have been recruiting dental providers in the State of Louisiana. These providers have signed Letters of Intent with our organization. The RFP includes a template for LOIs. Since we have several hundred providers already signed under an MCNA LOI, should we ask them to sign the LOI from the RFP or will the original MCNA LOI suffice?	No, DHH will not require Proposers to use new LOI as long as the proposer's is able to provide all the information being requested in Appendix F of the RFP.
147	MCNA	RFP	7.11.5.6	Provider Network Development Plan	34	Please define what temporary credentials are, per section 7.11.5.6.	During the transition period, DHH has allowed a sixty (60) days grace period from the date the contract has been signed to have all providers credentialed.
148	MCNA	RFP	9.7.1.6	Payment for Emergency Services	48	We want to confirm as discussed in the meeting yesterday, that transportation is limited to situations where there are no in-network providers.	The Health Plan is responsible for payment of all emergency transportation services related to dental.
149	MCNA	RFP	12.6	Member Identification (ID) Cards	64	This section states that the dental benefit program health plan will not provide members with a separate ID card, however, in section 12.4.3 (Welcome Packets), page 61, bullet 3, it states that the health plan member ID card should be included with the welcome packet. Please advise whether the DBP must provider member ID cards.	This is incorrect. The Health Plan will **NOT** be required to issue a member ID card. A correction has been issued in addendum #4.
150	MCNA	RFP	14.4.2	Member Satisfaction Surveys	82	This provision requires the DBP to perform CAHPS adult surveys, however, the RFP is only applicable to children. Is this still a requirement for the DBP? Additionally, this provision requires the DBP to enter into an agreement with a vendor to perform CAHPS surveys. Currently, MCNA surveys through the Member Services Hotline. Is the subcontract through a vendor still required?	DHH can not make a final decision at this time on this question.
151	MCNA	Appendix AA	D	Member Enrollment and Disenrollment	24	There is no D.2 in the grid, only D.1 and D.3.	This has been updated with Addendum #4.
152	MCNA	Appendix AA	E	Service Coordination	25	There are 2 "E.3"s and the point value for the first E.3 is only listed as 2 points.	This has been updated with Addendum #4.

RFP# 305PUR-DHHRFP-DBP-MVA
QUESTIONS AND ANSWERS (1-3-2012)

Question #	Submitter Name	Document Reference	Section Number	Section Heading	Page Number in Referenced Document	Question	DHH Response
153	MCNA	Appendix AA	F	Provider Network	28	Provider linkages are referenced in the scoring grid under F.1. Does that refer to the number of potential members that are in the same geographic area of each PCD? If not, please define provider linkages.	Yes, this refers to the number of potential linkages the providers can accept.
154	MCNA	Appendix AA	F	Provider Network	31	F.5 lists 510 points listed as possible.	Corrected with Addendum #3.
155	MCNA	Appendix AA	F	Provider Network	31	The second sentence in F.6 requires a process to permit members with chronic conditions to select a specialist as the PCD and asks whether the plan allows specialists to act as PCDs. Is this requirement applicable to dental?	Yes this is applicable.
156	MCNA	Appendix AA	G	Utilization Management	34	G.3 bullet (2); the statement says, "...with respect to bullets (2) through (7) in item L.1." Item L.1. does not contain 7 bullets, should this reference be"K.1"?	Correct, it should be K.1, this has been updated with addendum #4.
157	MCNA	Appendix AA	H	EPSDT	36	The point values appear to total up to 20 points rather than 25.	Points should total 25, this has been updated with addendum #4.
158	MCNA	Appendix AA	H	EPSDT	36	H.2; the statement says, ...the use of the tracking system described in I.1. above..." Should this read "H.1"?	Correct, it should be H1, this has been updated with addendum #4.
159	MCNA	Appendix AA	J	Member Materials	42	The point values appear to total up to 25 points rather than 50.	Points should total 15, this has been updated with addendum #4.
160	MCNA	Appendix AA	L	Emergency Management Plan	46	The point values appear to total up to 15 points rather than 25.	The points are correct.
161	MCNA	Appendix AA	T	Cost	63	The point values appear to total up to 850 points rather than 550.	Proposers will be ranked with the first or second quartile. The most any proposer can achieve is 550 points within the first quartile. Proposers that fall within the second quartile can only achieve a maximum of 300 total points.

Question #	Submitter Name	Document Reference	Section Number	Section Heading	Page Number in Referenced Document	Question	DHH Response
162	MCNA	Appendix AA	T	Cost	63	(a) How is "quartile" defined and applied? (b) What is the method for determining which quartile a company's bid is placed? (c) How will this methodology work with a scenerio where only 2-4 companies respond? (d) It appears as though a bidder could be the most costly by only $0.02 and be scored a 0 in the section if not within the first or second quartile. (e) In reference to section 21.20.4 of the RFP, how can a bidder fall above or below quartiles 1 and 2? (f) In order to fall above or below quartiles 1 and 2, are only the two middle quartiles being considered?	range will be broken up into quartiles. The rates will be divided into four equal sub-ranges, and the two lowest groups will represent the first two quartiles respectively. The upper end of the second quartile should reflect the median of the rate range. (b) Please reference the response to (a) above for determining how the quartiles are determined. The proposer's composite bid will be placed within any quartile based upon where the bid's numerical value falls within the quartiles. The quartiles are determined by the actuarially determined rate range and are independent of the bids; i.e. the bids do not affect the rate range or quartile determination. (c) Please reference the response to (b) above. The number of companies responding to the RFP has no effect on the rate range or quartile determination. (d) Cost proposals outside the first and second quartiles will receive a cost score of zero regardless of the dollar amount placing such bids outside the designated quartiles. (e) Please reference the response to (b) above. A bidder can fall above or below the first and second quartiles by its proposed composite PMPM being below the first quartile or above the second quartile of the certified rate range. (f) A cost proposal will receive a cost score if the proposed composite bid